LM Chadfield DO PLLC

Patient Name (print) ____DOB: _______________________

I authorize payment of medical benefits by the insured directly to LM Chadfield DO PLLC. I also request payment of government benefits directly to the party who accepts assignment. I understand that I am financially responsible for payment of all services or materials provided to myself that are not a covered benefit under my insurance. I agree to pay all services within 30 days unless a payment plan is negotiated in advance. I authorize LM Chadfield DO PLLC to release any information required to process my claim. This request shall remain in effect until revoked by myself in writing.

Authorization for Specific Confidential Communications

I authorize my physician and/or administrative and clinical staff to disclose the following protected health information to:

Name: ____ Relationship to Patient: ______________________________

Phone No. ( )__________________ Cell No. ( )_____________________Work No. ( ) ___________________

Name: ____ Relationship to Patient: ______________________________

Phone No. ( )__________________ Cell No. ( )_____________________Work No. ( ) ___________________

Select the Protected Health Information (PHI) to be used or disclosed to the above listed individual(s) from the list below

- Medical Care/ Treatment: Yes________ No__________
- Can a message be left on your answering machine/voicemail Yes___________ No______________

Names of the nearest 2 relatives (at least one with whom does NOT live with)

and whom we may contact in case of an emergency.

Name: ____________________________Cell No.( )_____________________Work No.( ) ___________________

Name: ____________________________Cell No.( )_____________________Work No.( ) ___________________

This authorization shall be in force and effect and does not expire until it is revoked in writing. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Contact at: 1025 Spaulding Ave. SE Suite B, Grand Rapids, MI 49546. I understand that a revocation if not effective to the extent that my physician has relied on the use or disclosure of the PHI or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. By signing below, I acknowledge that I have been offered a copy of this office's Notice of Privacy Practice Form.

Signature: ____ Patient Parent Guardian

Date: ____ (circle one)